STATE OF CONNECTICUT
OFFICE OF HEALTH STRATEGY
STATE INNOVATION MODEL PROGRAM MANAGEMENT OFFICE

REQUEST FOR APPLICATIONS (RFA) FOR PREVENTION SERVICE INITIATIVE – FOR HEALTHCARE ORGANIZATIONS

FOURTH Addendum

RELEASE DATE – 02-26-2018

PLEASE NOTE: THE DEADLINE FOR THE PREVENTION SERVICE INITATIVE – FOR THE HEALTHCARE ORGANIZATIONS RFP HAS BEEN EXTENDED FROM MARCH 2, 2018 TO MARCH 16, 2018 AT 3PM.

On February 16, 2018, two webinars were held regarding the Prevention Service Initiative. The first webinar was targeted to healthcare organizations, and the second to Community Based Organizations. The full transcripts from both webinars are available below. Additionally, written responses to the questions from the webinar are also below. The presentation slides will be posted here: http://www.healthreform.ct.gov

Please note that responses related to the Community Based Organization RFP are posted here: https://biznet.ct.gov/SCP_Search/BidDetail.aspx?CID=45454

1. **Question: Besides the Cover page, narrative and the Attachment A: Procurement and Contractual Agreements Signatory Acceptance, is there any other documentation that needs to be submitted?**

   Response: The applicant must submit the following. The corresponding page on which the instructions for each is located in the RFP is in the parentheses:

   - Cover Page (page 11)
   - Applicant Characteristics (page 11)
   - Application Narrative (page 12)
   - Attachment A: Procurement and Contractual Agreements Signatory Acceptance (page 21)

2. **Question: Can an Advanced Network use funds from this grant to pay for asthma home visit services or to support their own asthma home visit program similar to the New England Asthma Innovation Collaborative (NEAIC) (PowerPoint slides) that has demonstrated positive outcomes that align with the purpose of this grant? Otherwise, the only other asthma home visit program available is the CT DPH Putting on Airs which relies on renewable federal grant funding.**

   Response: An Advanced Network may not use the grant to pay for its own asthma home visit program. The aim of the initiative is to assist the healthcare organization in developing a formal contract with a CBO, and reimbursing that CBO for their services. The Putting on Airs program is one potential community-based program, but may not be the only one. Many, if not most, community-based programs proven to improve health outcomes rely on grant funding. The intent of this initiative is to promote new funding and referral streams from the healthcare organization to the CBO that benefit the healthcare organization, the CBO, and the patient.

3. **Question: My question relates to the funding for this initiative. So as a participant in PCMH+, we are being asked to participate in the Preventive Service Initiative as a contingent of our participating in PCMH+ Wave 2. And in the PCMH+ Wave 2 RFP there is a reference to the funding. And it talks about $100,000. Then it talks about $250,000. What is the anticipated funding for the Preventive Service Initiative?**

   Response: The funding available for the Prevention Service Initiative is up to $100,000 for each organization.

   The $250,000 amount that is referenced in the PCMH+ RFP is a separate supplemental award opportunity. Awards of up to $250,000 may be offered to existing Community & Clinical Integration Program Participating Entities. This award opportunity is unrelated to the Prevention Service Initiative opportunity.

4. **Question: Who would be providing home visit services through a CBO? Are we envisioning that the service would involve a community health worker role? And if so, is the anticipation that the healthcare organization would be paying the CBO to provide that service?**

   Response: As part of the Prevention Service Initiative, the healthcare organization would establish a new contract with a CBO and would pay that CBO for services which may include a Community Health Worker.

5. **Question: Can you explain the funding opportunity a little further?**

   Response: Please refer to response #2 in Addendum 2:

   https://biznet.ct.gov/SCP_Documents/Bids/45353/SIM_PSI_Healthcare_SECOND_Addendum_2-6-18_Final.pdf .

6. **Question: For an organization that is not "identified" by the State and has to submit the application process, is it realistic for us to work with an organization to meet this timeline? We have been looking at community organizations and I don't know whether they are officially recognized by DSS currently. And so I think they would have to undergo the process? For example, Putting on Airs is already "recognized." If we want to work with a different CBO, will they be able to apply?**

   Response: We are not requiring any State-level recognition or designation of the CBO, other than that it is legally permitted to operate in the State of Connecticut.

Prevention Service Initiative Webinar: Healthcare Organizations
February 16, 2018
1:00 pm CT

Coordinator: Welcome and thank you for standing by. Today's call is being recorded. If you have any objections, you may disconnect at this time. All participants will be on a listen-only mode for the duration of the call. During the question and answer period, if you would like to ask a question, please press Star 1. I would now like to turn the call over to Trish.

(Trish **Torruella**): Thank you, (Sarah). And thank you all who have joined us, for being with us this afternoon. Good afternoon. You've heard a little bit from our operator about the logistics. We will be holding questions until the end. But I'm going to go ahead and get started certainly with introductions. The SIM Prevention Service Initiative is a collaboration among the Connecticut Office of Health Strategy, the Connecticut Department of Public Health and now I'm happy to say includes Health Management Associations, HMA, we refer to them as a national consulting firm with tremendous breadth and depth of knowledge in states across the country and in Connecticut in current delivery system reform and linkages - linkages and networks. These are the folks who are going to be providing the technical assistance.

One of the things that I'm excited about is that HMA assembles a team that is specifically prepared to address the needs in Connecticut. So I think we are off to an excellent start. I am (Trish **Torruella**). And I Project Consultant for Sim within the Department of Public Health, Population Health. And I also have with (**Faina Dookh**) who is the Project Manager for the Office of Health Strategy State Innovation Model.

And then we also have two members of the team from MHA who will be providing the technical assistance (Karen Scott) who is a Principal with HMA and (Heidi Arthur) who is also a Principal.

You're going to hear from all four of us. We have designed the agenda to provide context as well as details of the 18-month TA plan. (**Faina Dookh**) and I will speak to Connecticut SIM and Population Health context. (Karen Scott) and (Heidi Arthur) were going to be speaking in linkage models, success factors, and evidence-based preventive care.

What I'd like to do is touch on these ever so briefly, so we have the Connecticut SIM and Population Health, the project overview in terms of what you will be seeing and learning about the prevention service initiative, and then getting into community linkages and community-

based prevention services with an emphasis on what has been successful in other parts of the country.

Towards the end of our webinar, we will touch briefly on the RFA. I hope you've had a chance to take a look at that. So we will touch briefly on the timeline and then open for questions. Just a quick reminder that we're asking you to hold questions and to ask them verbally rather than through Go To Webinar so that we can be sure to record those and be able to answer them. So, (**Faina**) I will turn it back to you.

(**Faina Dookh**): Thanks (Trist). So just to provide some context, the Prevention Service Initiatives is one of the leading state innovation model efforts and Connecticut is one of several states participating in the state innovation model or SIM initiative over four years. And this allows Connecticut to test a variety of innovative strategies and we're really driving toward four aims. The first that people across Connecticut are healthier, secondly that we have better healthcare, so the way care is delivered is improved, that we improve health and lastly that we reduce healthcare spending which is rising and projected to continue to rise.

And we're really excited to launch this latest SIM effort the prevention service initiative. This initiative builds on SIM push on the healthcare system to improve our it delivers care and holding the health system accountable. It also builds on our community engagement efforts and our emphasis on population health. Which means we really have to move beyond healthcare to empower those in the community including community-based organizations and local health departments to connect better with the healthcare sector leverage what they're already doing to keep people health.

Just as the healthcare sector is under more and more pressure to keep patients out of the emergency department, make sure patients are managing their chronic conditions, and as a health system is looking to integrate within the community so that we're addressing all of a person's needs that impact health and impact diabetes and impact asthma. And that includes molds. It includes ice infestations, access to a nutritious diet, and all of the other factors that are the focus of the preventive service initiative. So with that, I'll turn it back to you (Trish).

(Trish **Torruella**): Thank you (**Faina**). As you saw and heard, Population Health is one of five primary drivers that supports the SIM aims; healthier people, better care, smarter spending, and healthy equity. I really like this slide, especially the graphics because I think in very few words it illustrates the multiple interrelated factors that impact population. In

Connecticut, because it is part of SIM, the prevention service initiative demonstration will focus on diabetes and asthma, self-management, community placed and evidence-based programs.

And with that we are ready to go to our HMA team members and really get into the model and the technical assistance. So (Karen) I think it goes to you.

(Karen Scott): Thank you (Trist). Actually (**Faina**) did you want to comment on the preventive service initiative before I take over?

(**Faina Dookh**): Yeah, a couple of comments here. Just, you know, as we know for the people in our communities, making sure that there's diabetes and asthma is effectively managed, it really requires an all hands-on deck approach. It requires that person's commitment. It requires our healthcare organization. It requires our community-based organizations and it requires our local health departments.

And today in Connecticut what we've learned is that people have a really hard time in smoothly moving between these organizations to get what they need. So primarily this initiative aims to create new pathways between healthcare and our community organizations so that we're really creating a consistent avenue for patients so that they can access the resources that already exist in the community. So that they can manage their diabetes or their asthma.

And healthcare organizations are becoming more and more accountable to quality measures and spending. So what matters more and more that there's this connection to the community. And we know, and you know that health depends on a lot more than what happens in the four walls of the doctor's office.

So healthcare organizations, they're faced with a choice with this added pressure. They can either build services themselves or they can buy some of these needed services that they don't traditionally offer to patients like home visits, mold remediation, help with buying healthy food, etc. And the prevention service initiative builds on promising experience from across the country that's showing that when CBO's are prepared to effectively offer their services to health care organizations, everyone gains; the healthcare provider, the community organization, and especially the patient.

So with that, I'll turn it over to you (Karen).

(Karen Scott): Great, thank you (**Faina**). And as (**Faina**) said we really do view this work as building on a lot of the delivery system reform work that

Connecticut is already engaged in. And also building on what we're learning from these types of linkage model and partnerships between community-based organizations and healthcare organizations around the country. The focus of this work of this particular project will be on building the capacity amongst the community-based organizations and the healthcare providers, (unintelligible) advanced networks and the federally qualified health centers, so that your both able to enter into a contracting relationship for community-based preventive services.

And as (Trish) noted we're going to focus on chronic disease management in this project and can draw on some very strong evidence-based practices which are showing very strong impact with both respect to clinical outcomes as well as in managing high cost healthcare services utilization of (unintelligible) and hospital utilization.

So for pediatric asthma, those services are home visits. A patient and family education about asthma and medication management and environmental management as (**Faina**) was referencing, trigger controls and etc. And for diabetes, the focus will be on the evidence-based program of self-management and education as one key example of where we know what we can see very strong positive outcomes in terms of improved control of diabetes. And again and rebalance the use of healthcare services so that the focus is more on primary care and community services rather than hospital services.

Next slide please. So we've thought a lot and we've looked around the country to try to answer this question about what the value is to the community-based organizations for participating in the prevention service initiative. Why join this? Why participate in this new effort? And with the value of creating these formal partnerships would be for community-based organizations.

(**Faina**) mentioned that as part of the delivery system reform work in Connecticut, there is a focus on moving to value-based payment programs, value-based payment models instead of paying solely for volume and for the number of services. And these will be based in payment in the future for healthcare providers will very much be based on managing emergency use, managing hospitalizations as well as for clinical outcomes in chronic disease. So that's the focus or the attention on the healthcare side.

Why does … What does that have to do with the community-based organizations in terms of this project? We think that it really does create some new opportunities for CBOs to be involved in helping to improve the health of their communities. We think that it is an

opportunity to help strengthen the services that you currently provide and the ability to market those services to a broader - potentially to a broader audience. To work with us to build a greater infrastructure in business and financial skills that will be needed to sustain a contracting arrangement with healthcare organizations. It's a way of certainly, as you've heard, continuing to focus on the needs of the communities that you serve. And a way to be connected to what's happening in the redesign of the healthcare delivery systems in Connecticut.

Advanced networks and FQHC contracts can also provide for you an ongoing reliable source of funding. Potentially a way of expanding the population that you're currently service. A way to jointly think about how to evaluate performance and build more evidence for the value of these partnerships. And finally an ability to build a working relationship where you're also able to identify additional opportunities to expand your services into a greater population or to add new services that really meet the needs of the communities you're serving.

So just briefly, as the technical assistance vendor we conceptualize the project as focused very much on the objectives of providing technical assistance that's tailored to the needs of both the community-based organizations and the healthcare organizations who will be participating in the initiative. In order to strengthen the ability of both sides, of both partners to be able to contact with each other within a few months of starting this initiative.

Out interim outcome goals are that we're able to create a program that's engaging and helpful to all of the organizations participating and that we'll get active participation in the technical assistance project - process. And that that will lead to at least one contract between a community-based organization and one of the participating healthcare providers by the fall of this year, by November of this year.

And finally, we envision the work overall as an opportunity to help the community-based organizations enhance their business, skills, and in delivering services and working with the healthcare system improve performance on quality measures on the provider side and most important increase the number of patients who are receiving, again, these evidence-based services that we know will contribute to improving your health.

Next slide please. This is a detailed flow chart. But just to give everyone a sense that of what's envisioned in this process. There are a number of pieces to it. And in parallel, we envision beginning to work and provide technical assistance to selected CBOs. As well as to the

selected advanced network FQHC healthcare organizations who will participate. We will spend the first few months working to pair with - provide that technical assistance to both sets of organizations to get to a place of bringing everyone together to negotiate the contracts to be able to provide the services.

And then in the second half of the project once the contracts ae in place will continue to work and support all of the participants to make sure we've got ways of measuring and tracking. And evaluating how the process is going in terms of the business relationship as well as the outcomes for the (unintelligible) clients that you're serving. And now I'm going to turn it over to my colleague (Heidi) to talk a little bit more about the technical assistance.

(Heidi Arthur): Thank you. So this is, indeed, an initiative that is intended to really build capacity on both sides of that equation, both on the advanced network FQHC side as well as on the CBO side as (Karen) mentioned. This slide demonstrates just a couple of the areas that we imagined that the healthcare providers will require some assistance. We imagine that they'll be seeking some health around identifying who within the population they serve could best benefit from the kids of community-based more intensive innovations that we would be looking for the CBOs to be offering in the communities that are targeted. And really helping them to think through what metrics they want to be collecting and how they've been measuring and monitoring and really collaborating with their CBO partners in order to improve outcomes and really look at community health more broadly. This is just a snapshot. Other topics will likely be identified as we through the process.

The next slide. The next slide speaks to the - just snapshot of what we imagine the CBO capacity building would look like. We imagine that on the CBO side, there may be a need for assistance round thinking about service (unintelligible) to new populations, expanded populations, how to implement the evidence-based model in such a way to really go the distance within the communities that you serve and leverage what you're already doing and who you're already reaching in order to improve on those outcomes.

And speaking about financing models and, sort of, the business acumen necessary in order a level of service and set your cost at such a level to ensure that there's a return on (unintelligible) resources and time. As well being able to collect the right kinds of data and to collaborate effectively with health providers. Again, this is just a snapshot of the topics we imagine would be useful. Because we don't want to duplicate anything that folks might be getting from other

initiatives or efforts happening in the state. And we really do want to focus on building a collaborative.

Next slide. And building partnerships between the CBOs and the actual healthcare providers that are participating in this network. We understand from our work in other parts of the country that those relationships are really fundamental to the success of preventive initiatives like this one. And so, our sessions are going to, in some cases, target the specific needs that CBOs are bringing and specific needs that the advanced network some FQHCs are bringing. And then there are going to be sessions where we really bring everyone together and to share best practices, to provide subject matter expertise and to really, again, facilitate those relationships and build those connections.

We're going to be looking across the system to target the highest need populations and really ensue that this initiative addresses the most critical gaps in care. We'll be using a variety of methods.

Next slide. Including webinars, and in-person sessions, but we're going to start the process with a structured assessment in order to identify gaps within each organization so that a work plan is really organized to individualize the technical assistance that you receive. We're going to really make sure that those organizations that can support one other have the opportunity to learn in a peer-to-peer capacity and we'll be using coaching calls. Some of the topics that we imagine would be most beneficial really do have to do with the kind of business planning and financial modeling that often doesn't happen when people are responding to RSPs to address a specific goal. This is an opportunity to really think about what your population needs and what you feel is necessary in the community that you serve and then model out what would it look like for this to become a real service that you could expand on, enhance in the future or replicate.

(Karen Scott): Thank you (Heidi) and we included just a couple of examples that we wanted to touch on just briefly to show the power and also the lessons learned from some of the work that we're aware of happening around the country. And this, the first example of a linkage for community-based program of services comes from work in Baltimore where partnerships between several of the hospitals and Baltimore and the Baltimore Health Department led to a focus on asthma on home visits for families with at least one child with asthma, education for the family, and for the parent and child as well as educational, environment assessments and (unintelligible) of environmental triggers. Over time Baltimore has seen a decrease in hospitalizations among children participating referred to the program, improvement in

medication adherence, symptom-free days, and an increase in the parental knowledge.

What they attribute some of the success of the program to is (unintelligible) the focus on communication and a shared focus on coordinating the care for these children, a clear communication path both out to referred families to the health department as well as feedback to the referring physicians. The program's focused on key roles in the community health workers in doing the home visits, and a structured evaluation program which we are also building into this initiative. So that everyone involved in contributing to take - to provide care to this population, can be part of really tracking and being able to assess and report on the results and see the results of the work. (Heidi), next part?

(Heidi Arthur): Excellent. And Health People, this is a different initiative. This is an organization that New York City, they provide what they call community in reach within the highest needs areas of their South Bronx communities. Their peer educators provide street outreach to recruit participants from places like public housing and shelters, soup kitchens, community centers and sort of all over the map in terms of connecting to existing organizations in the community. But they locate. They educate. They support and advocate for. They link and escort clients to clinics and hospitals. That's how the role that Health People plays already in the community.

Within the past year and a half, they've enrolled about 768 participants at 36 sites throughout the Bronx area and the (unintelligible) self-management program. That's an evidence-based six-week session six-week course that is for people with diabetes And DSMP is conducted by the peer leaders who are recruited, trained and managed by Health People. They have an after-trainer status for DSMP and also for chronic disease self-management model They were able to contract with multiple Bronx hospital networks and that includes three FQHCs and they completed two rounds of the SMPs so far and they have two more (unintelligible) with contracts that are in process.

And so far, they've had a 77% attendance - participation rate, folks who have participated in four or more of the six sessions. So they completed - those folks that completed the Sanford program. And then the most recent evaluation, those participants maintained a .4% drop in their A1C a year after completion. So that's sufficient to help avoid long term complications, especially vascular complications like blindness and amputation. And they've also seen a significant decrease in depression. Health people actually provides its peers with three extra weeks of training aside from their required Sandford four-

day training because they know that it takes that to ensure that the community members, lots of whom have diabetes themselves are able to implement the program.

So this is takeaway in terms of what's in it to participate for a CBO in this initiative. Certainly, we understand that anything that's an investment of your time and energy is something that requires careful consideration and is definitely - it can be hard to patriciate in one more thing. But we feel that you're likely to agree that your community and your clients deserve integrated are for their interrelated needs and often the kinds of barriers that exist for populations for that you reach and uniquely reach there are gaps. And it means their access to care may not be as fluid as necessary.

(Unintelligible) population will build your internal capacity to enter into business agreements for health-related services in the future. It'll engage in the delivery systems design and you'll be able to bring your knowledge of the populations you serve, their language, their cultural needs to those health providers that can really improve the access to care based on the input and the experience that you bring.

You also - often CBOs bring access to services to address the social determinants of health to really complement the kinds of evidence-based models that are needed to engage these populations. And might otherwise also not be received by the folks that are targeted for these kinds of initiatives. And it really does poise you to develop similar services in the future. Funding streams can be created through these initiatives. This investment of your time could be a whole new source of revenue for your organization going forward. And certainly, the desire to address that health disparities that populations face, build a real sustainable model for community linkage and infrastructure that can be expanded to other groups and populations in the future.

(Karen Scott): Thank you (Heidi). (Trish) We'll turn it back over to you.

(Trish **Torruella**): Wonderful and thank you so much. I love listening to the experience and insight that you bring to this. What you have in front of you now are the key details of the request for application. You can see that the dates we still have ahead of us are the due date for the application which is March 9. Anticipated notice of award is March 23. And then, of course, the 18-month period when you would be involved with technical assistance and learning collaboratives would begin on April 1 and extend through September 30 of 2019. And I think you can see the anticipated number of awards and the eligible applicants. And again, you have access to the full RFA. There's a lot of information

there, but we wanted to make sure to touch on these in terms of the timeline.

And now we get to questions. As you see we've given a lot of thought in advance to hearing questions from you, but also making sure that we have an opportunity to record the questions and respond to them in writing. We have found that sometimes some questions are a little more complicated than others. So we will answer questions to the extent that we can. And then ask you to submit them in writing or we will record them and answer them in writing. And as you can see, the person to submit questions to is (**Faina Dookh**) and you see her email up on the screen.

So with that, (Sarah), I think we are ready to have our participants able to ask questions.

Coordinator: Excellent. If you would like to ask a question, please press Star 1 from your phone and speak your name clearly when prompted. If you would like to withdraw your question, please press Start then 2. One moment while we wait for the first questions. Our first question comes from (Neil). (Neil) your line is open.

(Neil Lustig): Thank you very much. My name's (Neil Lustig) Health Director for the Pomprock Health District in Southbury, Connecticut which is upper New Haven County. We've run about 15 diabetes self-management programs in the last four years. And about 15 or 20 matter of balance both evidence-based programs, matter of balance on falls. We did read the RFP. We are interesting. Unfortunately, it says repeatedly a couple of times in bold print this initiative is limited to Bridgeport, New Haven, Middletown and surrounding towns. We do not border any those three towns. And we just wondered if it's really worth our - is it worth the effort to even think about applying or doing the RFA because we're not in that clearly defined category? Or you will consider outliers? We've done a lot of these. We have a lot to offer the initiative because we've done so many of them. We have a team including community health workers already trained and we've got three or four more planned in the next couple of months. Thank you.

Woman: (Unintelligible).

Woman: (Neil), thank you so much for that question. And we did a lot of work in selecting these initial target regions based on a couple of factors. One is, you know, we're obviously taking a lot of attention to make sure that we're pairing effectively the healthcare origination and the community-based organization. So part of the selection is, you know, if we choose a CBO that doesn't service the patients that the healthcare

organization is servicing then that contractual negotiation isn't going to work. So part of it is that.

And then another part of the target region selection was looking at our population health data. And some of the regions that were of highest need in terms of a population health basis. Third is really based on this move to value-based payments. So healthcare providers in our state are being held accountable more and more by insurers for quality outcomes and for spending. And those are the healthcare provides that have the biggest business interest in connecting with the community.

So we also wanted to target those regions that have a high penetration of these accountability contracts and a value-based payment penetration. So a couple of factors went into choosing the regions. And so that's why we're starting with that set.

(Neil Lustig): So should we - I guess I'm just asking for a direct answer if you're prepared to give that. And it sounds like the answer is not really. It's not in your category. You don't - you're not that area. And you don't surround that area. Even though my population have 9-1/2% of the population has Type 2 diabetes. We're in the healthcare system. We work with the hospital systems, but I think I'm hearing that this is not an option for us with this particular grant. Am I hearing that correctly/

Woman: Right. So at this time we are targeting those three specific -

(Neil Lustig): Thank you.

Woman: Yes.

(Neil Lustig): Appreciate that.

(Trish **Torruella**): Do we have another question?

Coordinator: Our next question comes from (Andrea). (Andrea) your line is now open:

(Andrea Bosen): Thank you yes. Hi, this is (Andrea Bosen) from the Stratford Health Department. Thank you for the webinar I would like - my question is about the evidence of qualified entity and the sanction part of the transmittal letter. I know that sounds sort of mundane. But are - is this to be a separate letter or just simply (unintelligible) of attestation in terms of the disclosure. And it seems almost like the evidence of qualified entity is a separate letter that comes from our legal counsel or our town attorney?

Woman: So I know that this, kind of, boilerplate information we ask in all of our procurements. I would have to get back to you in writing about what specifically will suffice to meet that requirement.

(Andrea Bosen): Okay, thank you.

Coordinator: As a reminder, if you would like to ask a question, please press Star then 1 from your phone and speak your name clearly when prompted. Our next questions comes from (Suzanne). Your line is open.

(Suzanne): Hi, this is (Sue Gard) from Fair Haven Community Health Center. My question is can an FQHC function as a CBO if we have a product that we think is worth disseminating?

Woman: So because the initiative is really focused on enabling healthcare providers to connect with community-based organizations, a federally qualified health center in this case, we would bucket that in the healthcare organization category. So they wouldn't be eligible as a CBO as again our push is really to make those healthcare community linkages with existing community-based organization services.

(Suzanne): So again, I just would ask though if we have the services, if it's no different. I don't understand the rationale behind that because if we have a well-established, years in operation, diabetes program with self-management tools and are prepared to deliver, obviously someone would - I mean we would have to create the linkages to be sure. That's important, but I don't see why - I mean we're certainly not going to go make a linkage with another entity when we have these services in-house. And if we can market them, I don't see why - I think you're shooting yourself in the foot to eliminate that as a possibility.

Woman: So part of our experience in looking at other models is that when the service is provided by a community-based organization, especially some of the services that we've selected for this demonstration and other like services that it's really actually more cost efficient and potentially more effective when the community-based organization provides it. If we were, I guess, to allow what you're suggesting - what we're doing here is essentially supporting the healthcare organization through mostly technical assistance to develop this new contractual relationship. Otherwise -

(Suzanne): Exactly, that's exactly what we're looking to develop. I think, you know, what you're offering is something that we would be very interested in pursuing.

(Elizabeth Magenheimer): I think that - This is (Elizabeth Magenheimer). Part of that question is that within the city of New Haven specifically, and the relationships, larger relationships we are attempting to have some kind of a setup such that we could have a reimbursement model, a system of reimbursement. We now are - since we have fulfilled the Medicare requirements for reimbursement, but we would like to set up a larger system for reimbursement model for diabetes prevention with Medicaid. So the question then is we certainly can do it as an FQHC. Part of our continued rollout for the City of New Haven and for the state would be to make that model a reproducible model on a smaller scale at other institutions.

So I completely agree with you. We are - we don't want to be completely distinct on the one hand. On the other hand, we want to offer a model that can be used and transmitted to other institutions. So we can -

(Suzanne): When you say other institutions, what do you mean by that?

(Elizabeth Magenheimer): Just if other community health service systems want it. And any -

(Suzanne): Just think of it as no different than any other CBO, a business. A product that we are - I mean this is something that we have been working on in terms of a strategy for sustainability for a model that has worked here extremely well for a number of years. We have a tremendous in-house expertise and I just feel like, you know, I don't see why it has - why it can only be a one-way street in this equation.

Woman: I think we're not (unintelligible). I think that that definitely sounds like an interesting approach. I think here in this model, we're not - the payer in this case is not Medicaid. The payer in this case is actually the federally qualified health center.

(Suzanne): And advanced network, that's fine. That's what we're talking about. That is exactly what we're talking about. We're talking about establishing a business model for an FQHC that has a lot of experience in this area. And I don't know. I think well, I don't want to belay it. You may have other people on the call. But it just seems to me you're excluding an entity, not on very - I would be interested to hear a little more about the rational why you're doing that because it makes no sense to me.

Woman: Just to clarify, and you mean the relationship that would be formed would be between an advanced network and the advanced network

providing payments to you as a federally qualified health center instead to -

(Suzanne): Or another FQHC. I mean the same model applies. There's nothing about us being an FQHC from what I can see that precludes us being - I mean we are actively pursuing as we speak. This was a fortuitous occurrence in that it appeared at a time when we're literally involved in strategic plans to expand what is a very robust model beyond our four walls. And this is an opportunity to do that. And I - that I think could benefit the community.

Woman: So we hear what you're saying. I think we're going to take that into advisement and maybe talk a little bit more internally about your question.

(Suzanne): Thank you. And I have one other question if I can just follow up. A hemoglobin A1C drop of .4% on the diabetes program in the Bronx? I mean that's negligible.

Woman: Sounds like that was not a question, more a comment.

(Suzanne): Yeah, it was a comment. I actually, the question was I was wondering if was an error because it seems so negligible. I was just wondering if it was an error, that's all.

Woman: (Heidi) do you have a comment on that.

(Heidi Arthur): Sure, they maintained an average .4% drop in their A1C a year after completion.

(Suzanne): Okay, thank you.

Woman: Thank you. (Sarah) looks like we have time for one more.

Coordinator: Our last question will come from (Sherry). (Sherry) your line is now open.

(Sherry): Thank you so much for taking the call. My question has to do with the, not so much the application process, but the entity that may be eligible to apply. One of the things that we've been working on is building more of a collaborative structure so that a number of organizations can engage in these initiatives. What are your thoughts about an applicant who is looking to build - receive the technical assistance, build the business acumen on behalf of perhaps more than one community-based organization, more than just the applicant. Is

that something that would be desirable so that we can include and have as many participate as possible?

So for an example, our organization perhaps could serve as a backbone organization in the business acumen of receiving referrals in a secure setting, developing the contracting arrangements while supporting the smaller community-based organizations or other organizations do the actual ground - on the ground delivery.

Woman: I think that's a really interesting question and I will say if you can deliver that to us in writing with a little bit more information on the potential backbone organization, I think we will need to talk about that internally. But that's a very interesting idea.

(Sherry): Thank you.

Woman: I think we have time.

(Trish **Torruella**): Do we have time for - do you have someone in the queue (Sarah)? Looks like we might have time for one more.

Coordinator: I have (Andrea) in the queue. (Andrea) your line is open.

(Andrea): Yes, thank you. I have another question I wanted to ask. The initial award is for $20,000 and then it says after three months based on some, you know, on eligibility you could apply for an additional $30,000. Is there like a set criteria for that? Or?

Woman: So the rationale for this kind of two-phased approach is that the community-based organization at this point doesn't - may not necessarily know what investment they need to make to execute an agreement. You know, they might not know which health care organization is coming in. They might not know what their gaps are. Until HMA as a technical assistance vendor really comes onboard and helps them with their business plan, helps with their assessment and so the hope is that those that participate in this initial technical assistance process through the current procurement will be eligible to apply for this next phase of funding once they have a better understanding of their needs in terms of launching the agreement.

(Andrea): Okay, all right, thanks.

(Trish **Torruella**): So I think that concludes our time together this afternoon. I want to thank you thank you again for being with us and for really thoughtful questions. We will have a link to the recording of the webinar as well as the slides and if, by chance, you have a colleague or someone else

in your organization that might be interested in getting the information directly, you can do that. And again, to let you know that you can submit questions in writing directly to (**Faina Dookh**).

So with that (Karen) and (Heidi) anything else that you'd like to say by way of closing?

(Karen): No, it was a great discussion. Thank you all. Thank you (Trish) and (**Faina**). We look forward to working with everyone.

Woman: Thanks everyone.

(Trish **Torruella**): Thank you so much.

Woman: Bye-bye.

Coordinator: Thank you for your participation in today's conference. You may disconnect at this time.

END

Prevention Service Initiative Webinar: Community Based Organizations
February 16, 2018
1:45 pm CT

Coordinator: Welcome and thank you for standing by. At this time, all participants are in a listen-only mode. During the Q&A session if you'd like to ask a question, press Star 1 on your phone. Today's call is being recorded. If you have any objections, please disconnect at this time. Now I'd like to turn the call of to Miss (Trish Torruella). Ma'am you may begin.

(Trish Torruella): Thank you (Ted). Good afternoon everyone. And thank you for joining us on this webinar. The SIM Prevention Service Initiative is a collaboration among the Connecticut Health - Office of Health

Strategy, the Department of Public Health, and I'm happy to say now, Health Management Associates. HMA, as we refer to them, is a national consulting firm with tremendous breadth and depth of knowledge in states across the country as well as Connecticut. They touch on many different topics but some of the ones that we will be focusing on are the current delivery system reform, the importance of linkages and networks. And what HMA will be doing with us is providing a technical assistance process over 18 months. To help healthcare organizations and CBOs to address linkage models in the community.

So I am (Trish Torruella). I'm a Project Consultant with SIM in the Department of Public Health Population Health. And with me are (Faina Dookh) who is a Project Manager with the Office of Health Strategy State Innovation Model and from HMA we have (Karen Scott) who is a Principal with HMA. And (Karen) would you introduce some of the other members of your team that are joining us today?

(Karen Scott): Sure, I'm happy to. And also joining me is (Katy Secon) a Consultant from (unintelligible) as well. And (Kathy) has an extensive background in working with healthcare organizations and quality of care.

(Trish Torruella): Thank you (Karen). And one of the things that I wanted to do from the very beginning is to make sure to clarify that when we say healthcare organizations, we're talking about Advanced Networks in Federally Qualified Health Centers with attributed patients in the Bridgeport, New Haven, or Middletown regions. We have found that ANFQHC gets to be a bit cumbersome but wanted to make sure that we had clarified that from the outset.

So with that, I'm going to do a very brief review of the agenda. You will be hearing from all of us, (Kathy), (Karen), (Faina) and myself. We have designed an agenda to provide context on the Connecticut state innovation model as well as the prevention service initiative. In addition, with HMA staff team members, we will talk about the linkage model's success factors in evidence-based preventive care. So that (Kathy) and (Karen) will be going in more depth with you about what the model is, what the technical assistance looks like.

And then finally we will touch briefly on the RFA which I hope you have had a chance to look at. So what we will do on this call, on this webinar is to touch on the timeline, the important dates. And then we will tell you a little bit more about asking questions in writing. But for you know that as the operators said what we will do is we will hold

questions until the end of the actual presentation and then open it up for questions from anyone on the line.

And with that, I think we go to (Faina).

(Faina Dookh): Great, thanks (Trish). So just provide some context, the prevention service initiative is one of the latest state innovation model efforts. And Connecticut is one of several states participating in the State Innovation Model or SIM initiative over four years and it allows Connecticut to test really a variety of innovating strategies and our hope to drive towards our four aims. That people in Connecticut are healthier. That we have better healthcare. That we move towards health equity and that we reduce healthcare spending which is rising and projected to continue to rise.

And we work closely with a lot of healthcare providers across the state, likely many on this call. And we're really excited to launch this latest SIM effort the preventive service initiative. This initiative builds on SIMs push towards value-based payments and towards new ways of delivering care. It builds on our efforts to provide support to healthcare organizations as they try to figure out to truly transform care and how to succeed in these new alternative payment models. The preventive service initiative in combination with our other SIM efforts supports healthcare organizations as they work to perform consistently on quality measures like emergency department use, diabetes control. We're helping healthcare organizations focus on smarter spending and value not volume. And to integrate with the community so that we're able to address all of a person's needs that impact their heath and their asthma and their diabetes including molds, mice infestations, access to nutritious diet and other factors that are the focus of the prevention service initiative.

And with that I'll turn it back to (Trish).

(Trish Torruella): So as you saw in the previous slide and heard from (Faina). Population health is one of the five primary drivers that supports SIM aims; healthier people, better care, smarter spending and health equity. And in this particular slide, we are addressing directly the factors within population health that we are looking to impact. So on the left-hand side of the slide, you certainly see social determinants of health, community place care. The emphasis on asthma and diabetes self-management. The idea of eliminating health disparities and certainly reducing emergency department and inpatient hospital use.

This, I have to say, is my favorite slide because I think it illustrates the multiple interrelated factors that impact population health. And in

Connecticut with the PSI demonstration, we will be focusing specifically on diabetes and asthma self-management and in the three regions that I mentioned earlier. So back to (Faina).

(Faina Dookh): So we know that for the people in our community, making sure that their diabetes and their asthma is effectively managed. It really requires an all-hands on deck approach. It requires the person's commitment. It requires our healthcare organization. It requires our community-based organizations and it requires the local health department. And today in Connecticut what we're hearing is that people are really having a hard time smoothly moving between all these organizations to get in what they need to effectively manage their chronic conditions.

Primarily, this initiative aims to create new pathways between healthcare and our community organizations. To create a consistent avenue for patients to access resources in the community to help them with their diabetes and their asthma. Healthier organizations, as you know, are more and more accountable to quality measures and to spending and it matters more and more that there is this connection to the community. And we know that health depends on a lot more than what happens just inside of the four walls of the doctor's office.

Healthcare organizations are faced with a choice of building themselves or buying some of the needed services that patients need that they don't traditionally offer like home visits, mold remediation, help with buying food, etc. The preventive service initiative builds on a promising experience from across the country that is showing that when healthier organizations choose to buy existing services like these from established community organizations, everyone gains; the healthcare provider, the community organization and especially the patient.

So with that I'll turn it over to (Karen Scott) with HMA.

(Karen Scott): Great, thank you (Faina). And as (Faina) said we're really building this initiative around emerging evidence-based practices both around the importance of collaboration, partnership and linkages between healthcare organizations and community-based organizations. And also around highly effective community-based preventive services with respect to achieving improved clinical outcomes for our populations as well as improving appropriate use of healthcare services and better managing use of emergency (unintelligible).

The community-based preventive services that particularly interested in expanding through this initiative include: focus on effective asthma

strategies with include home visits, education for (unintelligible) caregivers, managing the environment and mitigating environmental triggers. For diabetes, a key focus will be in implementing and expanding the diabetes self-management and education programs Which again, have been shown to be effective in improving (unintelligible) control, patient adherence and reducing the need for emergency department in hospital and inpatient hospital care.

To just go back to the center of the slide for a moment, I want to just reiterate (Faina)'s focus on the linkage. And some real focus in this particular project is to test this idea of contracting between two organizations and community-based organizations as a way of focusing on the long-term change to the system and sustainability could be to ensure these services are provided to a broad population at risk.

Next slide. (Unintelligible) to why you as healthcare organizations might participate. And how to make sure we're building something that will provide value to you in a number of ways. So firstly, this initiative is really designed to support success in (unintelligible) models of care. And within the value-based payment model, certainly measures related, (unintelligible) measures related to emergency department use, inpatient care, but also medication management and disease control for asthma and diabetes will very much be the kinds of (unintelligible) that you as providers will be held accountable for. And setting goals in order to be successful in the (unintelligible) payment world.

Again, these are - we want to focus on interventions that have been shown to improve outcomes, so they will support your quality scores (unintelligible) and as you'll hear more about later in the presentation (unintelligible) initiative there is some funding (unintelligible) to get started in developing these contracts. But we also think beyond value-based payment, this is really an opportunity to think about - think broadly about how to best serve a population, the full population that you're serving. And what the opportunity is to leverage what some of the community-based organizations can bring to your patients as well.

For many healthcare organizations, partnering with CBOs is a way to engage some of the hardest to reach patients within your population. It's an - it provides a greater ability to address some of the nonclinical factors and the social determinants upheld (unintelligible) that are beyond your purview or readily or ones that are not readily available to address. The way of providing a cost-effective service in terms of the community-based services and it allows for an efficient use of your

time as providers. You're able to really focus on the clinical needs of your patients when they're with you.

Next slide. In terms of the technical assistance project and the work of health management associates, we're envisioning this work as an ability to support and provide technical assistance to both the community-based organizations and the advanced network (unintelligible). We understand each organization is in a unique place and so that (unintelligible) to be very much tailored to something that's of value and helps you progress towards the ability to contract with the community-based organization.

Our interim outcomes and goals are both to have active participation in the technical assistance and by November of this year achieve at least one contract between provider and CBO. And finally, our overall outcomes and goals jointly for this program is to increase the number of patients who are being served and receiving (unintelligible) preventive services in the community. On the CBO side, support the (unintelligible) service delivery skills as needed. And on the healthcare organization side, to put your ability to improve performance on quality measures.

This is a busy slide, but to recognize that there are two streams of work going as we start this project. One stream of technical assistance for the community-based organizations and a second for the healthcare organizations to hopefully bring us to the point of the diamond in the center when we are helping you negotiate contracts which specific services. While we will work with each set of organizations participating in the initiative, we also want to make sure that we're finding time to bring you together with your colleagues, with your other healthcare organization colleagues as well as with the potential CBO partners. So that you're really jointly understanding the needs of the populations that need to be served and how you can best work together.

And (Kathy) will not talk a little bit more about that technical assistance.

(Kathy Secon): Thank you. In this slide as well as the next three that follow are intended to give you a high-level overview of what we envision as the type of services and the topics that we'll cover as the technical assistance. But I should really frame that as saying this is a starting point in all of the technical assistance will be customized for each participant based upon the needs that you identify with the most helpful for leveraging and enhancing your capacity to do this work.

But this particular slide is an example of the types of assistance we anticipate. Some areas of work based upon work that we've done across the country to -based upon the literature that we've seen. We certainly think in terms of working with the advanced network and the FQHCs that we could envision doing some work around detailing the referral processes perhaps, you know, looking at the design and reliability of some of your clinical workflows. Understanding really what the goal is for meeting the needs of your particular patient population.

Are others also getting?

(Trish Torruella): Yes, we are. (Ken) are you hearing this?

Man: (Unintelligible).

(Trish Torruella): I hope not.

(Kathy Secon): There we go. Okay, I think we've got it now.

(Trish Torruella): Oops, it's persistent.

(Kathy Secon): Yeah.

Man: (Unintelligible).

(Trish Torruella): I'm going to try. Okay, did it stop?

Woman: It stopped.

(Kathy Secon): Okay so -

(Trish Torruella): Let's -

(Kathy Secon): Let's hope that it stopped. But I was saying is, you know, we anticipate that we'll be working with you with regard in particular to the referral process, perhaps some of the clinical workflows. Population health analytics and measurement as (Karen) and (Faina) mentioned are really important. And of course, this is a collaborative project So developing, you know, the communication structures and identifying the population that most likely to benefit from this work and the metrics to really evaluate how well we're achieving those goals, you know, will be important.

And similarly as you look at the next slide, we are expecting to offer the same type of assistance to FQHCs although we anticipate that - the

CBOs rather, I should say. That the CBOs will be perhaps at a different point along the spectrum with regard to any of these particular areas. But I would think particularly we might need to do a different type of work with them around some of the financial analysis. Perhaps even some of the quality improvement work. Helping them to really understand what needs to be in place with regard to the systems and the structures and metrics. So that they can help you determine or work with you to determine exactly what they can best provide your needs for your patients with regard to, you know, implementing some of the evidence-based practices and measuring some of those outcomes.

And then next slide really talks about some of the ways that we are planning to deliver the services. We know that your agenda and your day is crowded. We know you are participating in a number of different initiatives and collaboratives. And we recognize that we need to make sure that the material and the assistance that we provide to you is value-added. We'll work very hard to recognize unique needs of each group. So some of these learning sessions and webinars will be targeted to each specific participant whether that be the CBO or advanced network FQHC.

On the other hand there are going to be times where we'll have the opportunity to bring you together. This is a collaborative project and think that it's really important that you have the opportunity to build those relationships, to learn from one another and do some peer to peer mentoring and benefit from those services. And particularly to understand the needs of the target population where there are gaps in care that will help better meet those patient needs. Which entity is really best able to help deliver those services?

So the following slide really provides just a list of the different types of methods and tools that we anticipate in plugging in this work. We'll absolutely tailor tools to help meet the needs of the organizations, but we do have a number of structured assessments that we have used in other projects that will give us a starting point whether that be around the gap analysis. Which will be our first sketches really an assessment of each organization to identify, you know, the patient population, and the gaps in services that can best be met by this particular initiative. The contracting readiness tool and we also have some financial forecasting tools that we can bring to bear on the project.

We also, I think, also was ultimately just wanted to make sure that we help you to achieve implementation of a model that can be used for future replication. We understand that diabetes and asthma are only two of the chronic conditions that, you know, patients have. And areas

where you might want to scale this particular initiative or employ in other areas would be helpful. And so having a model to move forward is something that we will work closely with you on. And taking advantage I think of some of the data systems and registries that you currently have in place. And developing metrics that make sense to help evaluate the performance of this particular collaborative as well as each of the participants in moving forward for that.

And I think (Karen) I can turn it back over to you for some of the examples of work that we've done in other areas.

(Karen): Great, thank you (Kathy). I just very quickly want - we wanted to highlight a couple of examples of what we're thinking about and what we think is really exciting work for us to learn more about and to leverage and expand with all of you in Connecticut. The first example, an asthma program is a relationship between hospitals in Baltimore, their outpatient services and the Baltimore health department. Where a select - set of services including home visits, education for children and caregivers, as well as the environmental assessments. And addressing triggers in the environment have really led to a set of impressive outcomes in terms of decreased hospitalizations, improving medication adherence, symptom free days and increasing parent knowledge on asthma symptoms and triggers.

The strength of the program has really been built around formal communication and shared information between the healthcare organizations and the health department. A very much common set of goals and practices in terms of coordination of care employing community health workers to conduct - to be trained and conduct the home visits and sharing as well and evaluation programs. So they're both following collecting data and tracking and the results of the program as they progress. They can - so they are continuously learning from the progress of the program as well.

And the next example very briefly is one from New York. And describes a contact and relationship between several hospitals in the Bronx. And a community organization called Touch People. This is an organization that has trained members of the community to conduct their Stanford diabetes self-management program. And then engage members of the community really going into the community to identify people with diabetes who would benefit from the education program receiving referrals from the hospitals, But and then following up on those referrals by very much being on the ground in the community engaging peers to both help draw patients to the training as well as to deliver the training. And they're beginning to see some very tangible outcomes from that work.

In the past year they've enrolled over 700 participants in sites across the South Bronx. They're beginning to see members who have completed - 77% of the participants have completed all successions. They've maintained a, over the course of a year, on average a drop of .4 in their A1C. And they're seeing decreased levels of depression in that population. So linage to care and stronger supports in the community are really making a difference in the South Bronx population.

So why participate? Well again, we know that there is a lot going on in Connecticut in the delivery system and through population health activities. And that consideration of joining another project or initiative requires your careful consideration. But I hope that you'll agree that there's some exciting opportunity here. First and foremost, to make sure your patients are getting - fully getting all of the care and being able to maximize their health outcomes. But also that this is a continued way that you can be participating in redesigning the delivery system that you work in. That you can use these services to help address some of the social determinants of health that your population is facing. And at the same time, address the potential challenges that you may be facing in terms of being able to work efficiently to serve your whole population to - as well as to prepare for reimbursement under value-based payment programs.

Next slide. And I will turn it back to (Faina) to talk about the RFA.

(Faina Dookh): So here on the screen you just - you see the basic information above the RFP that's currently out. And the application due date is March 2 and you'll see here the period of participation and the estimated award amount as well as who's eligible. And we do take questions on a rolling basis. Those questions are posted publicly as a formal addendum and when you submit your questions to me, I'll, you know, I send the link out to that website as well.

But we wanted to leave this last segment of our presentation for your questions and leave some time for discussion now.

Coordinator: The phone lines are now open for questions. If you'd like to ask a question over the phone, please press Star 1 and record your name. If you'd like to withdraw your question, press Star 2. Thank you.

(Trish Torruella): Do we have questions?

Coordinator: Not yet, however I believe a few of them are popping up here.

(Trish Torruella): Great.

Woman: (Faina) there is one question in the chat section.

Woman: I responded (unintelligible) audio.

(Trish Torruella): If you do have a question in the chat, if you wouldn't mind doing the Star 1 and asking it verbally, that would be great.

Coordinator: There's a question in the queue for (Kirsten). Your line is now open.

(Kirsten): Hi, good afternoon. Thank you for hosting the webinar. I really appreciate the comments from everybody who's on the phone. And I look forward to meeting you at some point in the next few years. My question relates to the funding for this initiative. So as a participant in patients at a medical home, we've - one, we are being asked to participate in a preventive service initiative as a contingent on our participating in PCMH Plus Wave 2. And in the PCMH Plus Wave 2 RFA there is a reference to the funding. And it talks about $100,000. Then it talks about 250,000. And we just want to make - have a question for (Faina) around what is the anticipated funding for prevention service initiative? Because in the PCMH Plus Wave 2 documentation, it had two conflicting sets of information.

(Faina Dookh): So I would first point your attention to an addendum that was released that tried to make concrete the funding available. But the funding available for the prevention service initiative for healthcare organizations is $100,000 for each healthcare organization.

(Mark Shaeffer): This is (Mark Shaeffer). If I can jump in as well. The - I think we anticipate (Kirsten) that 30,000 - a total of $60,000 of the $100,000 would be earmarked for PSI service costs. That is payments to CBOs for the service. And so the amount that an organization, advance network or FQHC is eligible for would depend on whether they have one or two CBO contracts.

The $250,000 that's referenced in the RFP is a separate supplemental award, and estimated amount for other activities, basically other opportunities will likely will not be so finely prescribed. And we anticipate putting that opportunity out sometimes in the latter part of March. And $250,000 is an estimate. Where that number ultimately lands, it may be a little higher depending on how many - how or overall cease of budget is winding out with Wave 2 participants.

(Kirsten): Great, thank you so much for the clarification.

Coordinator: And once again, if you would like to ask a question over the phone, please press Star 1 and record your name. Thank you. There's another question in the queue from (Mike). Your line is open.

(Mike Cordulo): Yes, this is (Mike Cordulo) from Children's Medical Group. And my question has to do with who would be providing home visit services through a CBO? Are we envisioning that that would involve a community health worker role? And if so, is the anticipation that the grant money to the healthcare provider - healthcare organization would be paying the CBO to provide that service?

Woman: (Mike) I just wanted to clarify your question. You're asking whether the - a community health worker would be providing the asthma home visit. And if so would the healthcare organization be paying the CBO to provide that service? Did I get that right?

(Mike Cordulo): Yes. Or how else might that be funded or reimbursed?

Woman: Your understanding is correct. The healthcare organization would be paying the CBO as part of this new contractual arrangement. And we are anticipating that community health workers will be part of the prevention service model that's delivered by the community-based organization.

(Mike Cordulo): Great, thank you.

Coordinator: There is another question in the queue from Dr. (Hunt). Your line is now open.

Dr. (Hunt): Good afternoon everybody. Can you explain that a little bit further? In the guidance that we saw in the RFP, there was a percentage in the first six months gives the CBO a percentage in the second month. And then if the ROI shows value, then there would be a third round or an expectation. Can you explain that concept? And then Number 2, is when we're looking for a CBO partner that may not already be identified at this state, how difficult will it be for a new CBO to identify themselves under the application process and move forward? And will it make this timeline for this RFP?

Woman: So (Mike) I'm going to go ahead and answer your first question first. So in terms of the actual reimbursement expectation, so the state is providing funding to help the healthcare organization to jumpstart these contracts. And we're providing 80% of the cost of the contract for the first six months and then 60% for the next six months. And the rationale here is that, you know, the healthcare organization for this to really be sustainable and for the healthcare organization to be really

committed to this, we're asking them to contribute the remaining percentage so that there is that commitment and pathway to sustainability. And so after the 12-month period, the healthcare organization will make a determination based on the return on investment and impact on quality measures whether this is a good ongoing investment. We're hoping that it is.

I'm going to pause there to make sure that that clarifies it and ask you to just repeat your second question.

Dr. (Hunt): Before I repeat the second question, can you - so explain it. So 80% in the first six months, 60% in the second six months and that's out of the $100,000, correct?

Woman: No, so there's actually an addendum that I want to point you to that's on the business website that actually creates a hypothetical table for what the total contract would be and what the actual healthcare organization contribution is. And in this hypothetical example, the total healthcare organization contribution over the 12-month period is around $13,000. And it breaks out for each category what the award would be and the percentage the state would cover. And the percentage the healthcare organization would cover. And again, just contribution by the healthcare organization could be less than that if they so choose that in their contract negotiation.

Dr. (Hunt): And then the second question that I had was for an organization that is not quote unquote identified and has to submit the application process, is it realistic for them for us to work with an organization to meet this timeline?

Woman: So we have a - we currently have another procurement that's soliciting the community-based organizations with a similar timeline of the application deadline. I guess, can you clarify your question about identifying the CBO?

Dr. (Hunt): Yes, so we've been looking at community organizations and I don't know that they're officially recognized by DSS currently. And so I think they would have to undergo the process for which I think they listened to in the previous 45-minute WebEx. I - there's some concern that those organizations may not be able to meet the timeline in order to get this done. And/or understand the difficulty of being recognized. So is it a - how much will the established CBOs that are already recognized the state be preferred versus perhaps new entries?

Woman: So when you say already established or currently recognized, what do you mean by that?

Dr. (Hunt): So if you look at the (Healthy Heirs) program they're already recognized. They're somebody that we could start working with and identifying a potential relationship today. If we wanted to work with a community (Unintelligible) for example. They're going to have to submit and be identified as a CBO and go through that process of being recognized, correct?

Woman: No, so we're not asking for any recognition other than that is an existing community-based organization. And but we are limiting it to diabetes self-management program and asthma home visiting program based on, you know, the strong evidence there is on ROI impact on quality measures to date. But other than that, we're not requiring any other recognition or designation.

Dr. (Hunt): Great, thank you.

Coordinator: I'm showing no further questions at this time.

(Trish Torruella): Thank you so much (Ted). Let me ask you a question. In terms of having a little bit of time with (Karen) and (Kathy), do we need to actually go to a separate call or do we continue this one?

Coordinator: If you would like to end this current call, I can place you into the post-conference.

(Trish Torruella): That would be great.

Coordinator: Okay. This concludes today's call. Thank you for your participation. You may disconnect at this time. Speakers, please stand by.

(Trish Torruella): Thanks, (Ted).

Coordinator: You're -

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